

~~HAYWARD (G.G.)~~
~~Robert H. Smith's complaint~~

A Complicated Case
OF
Labor at Eight Months.

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BOSTON.

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A CASE OF LABOR AT EIGHT MONTHS:
SHOULDER PRESENTATION, VERSION; AD-
HERENT PLACENTA. CHILD WITH IMPER-
FORATE RECTUM: OPERATION, RECOVERY.¹

BY GEORGE G. HAYWARD, M.D.

Mrs. T., a young and rather delicate woman, under my care for her second gestation. This she was very anxious about, as the first had terminated unfavorably with a miscarriage at about the fifth month, brought about by fright. She became pregnant for the second time in the latter part of May (catamenia ceasing about the 25th, bringing the expected confinement early in March. Her general health had been very good throughout gestation, and she was able to take a proper amount of exercise, and showed her condition very little.

January 24th she was thrown from a sleigh, and not feeling any injury at the time, insisted upon walking home.

Two days later I was called, and found she had been talking the matter over with her friends, and had become very nervous. Rest was enjoined, and small doses of bromide of sodium given at night. No ill results followed, and she was soon able to be about again.

February 4th, she fell upon the sidewalk, and three days later began flowing slightly; this was increased upon movement. Rest was again enjoined, with careful watching, the flowing soon ceased.

February 11th, about noon she began to feel pains in the lower part of the abdomen, and was at first inclined to attribute them to the bowels. In fact, she

¹ Read, by invitation, before the Obstetrical Society of Boston, March 12, 1887.



had a movement of the bowels at about this time. But as the pains continued growing stronger and more frequent, she began to realize that it was probably something more serious. I was not called until about eight in the evening. Pains were at that time every ten to fifteen minutes, and not severe.

Abdominal and vaginal examination combined, revealed the following state of affairs, namely:

A small child, placed obliquely, with its head in mother's left iliac fossa, breech at fundus to the right, back anterior, membranes intact, os admitting two fingers, right shoulder presenting at the brim. Presenting part freely movable between the pains. Fœtal heart 150, regular.

The patient was now placed upon the left side, with the hope of inducing the head to engage. This, however, failed, and at nine, P.M., the condition of things was not materially altered. The os at that time would admit three fingers. The arm and shoulder presenting.

Fearing that the membranes would soon rupture, rendering version more difficult, and that the arm might be forced down, podalic version was at once determined upon (Braxton Hicks method).

Accordingly, the bladder and rectum having been previously emptied, and a vaginal injection of 1-3000 sublimate given, ether was administered, and the patient brought to the edge of the bed, in the left lateral position, thinking that this would rather facilitate the version. The right hand was introduced into the vagina, antiseptic precautions being fully observed. Three and finally four fingers were introduced within the os, and by so doing raising the presenting part somewhat, and passing behind it. The membranes were ruptured as high as possible, and by the combined method both feet were easily secured, and brought well down into the vagina. The dorsal position was then assumed, and uterine contractions soon

followed, and with them came the breech and body, (dorsum anterior). No traction was used.

The arms were easily freed in the ordinary manner. External rotation was complete, the occiput came to the arch, and the head quickly descended into the inferior strait. Here some little difficulty was experienced in flexing the head, owing to the rigidity of the perinæum.

The pulsation in the cord up to this time had been good, but it now ceased. Perhaps a minute was lost before extraction by (Smellie's method) could be effected. 9.30 P.M. Preparations for forceps, on the aftercoming head, were made, and had the latter failed, would have been resorted to. The child (female) was asphyxiated. The mucus was expelled from the mouth and nostrils, artificial respiration, blowing in the child's mouth plunging it in hot and cold water alternately, and all the various methods were tried, during the half-hour spent in resuscitating it. The child was then wrapt in a warm blanket and cotton-wool, and placed in a deep basket over the steam-heater. Hot-water bottles were placed at the child's feet and body. And a very even, warm temperature was thus maintained.

On returning to the patient, the placenta was found to be firmly adherent, antiseptic precautions were again taken, and the right hand following the cord was passed up into the uterus, to the attachment of the placenta, which was found to occupy the upper uterine segment a little to the left side. The placenta was carefully detached and brought down at 10.20 P.M.

A vaginal injection 1-3000 sublimate was then given, and two drachms of the fluid extract of ergot, administered. The uterus contracted well, and remained so, and there was very little hæmorrhage. The antiseptic method being used the binder and pad were then applied. A little later the patient was given some warm beef tea, and she soon dosed off into a re-

freshing sleep. An uninterrupted convalescence followed, the temperature never rising above 98.8° nor the pulse above 80.

The milk appeared on the third day, but was thin and watery, and the child refused it. Nursing was abandoned, and the breasts were supported and rubbed.

February 12th, the day following the birth, an attempt was made to give the child some little nourishment. Breast milk and goat's were both tried, and rejected, nothing was retained. Later in the day, as no urine or meconium had been passed, an examination was made, and the child was found to have an imperforate rectum. The orifice of the anus was present, and through this the probe passed into a cul-de-sac, the depth of three-quarters of an inch.

Examining still farther, the urethra was not to be found. Dr. Porter was called in consultation, and verified my diagnosis; he advised deferring any operative measures until the next day, and quoted a case in his own practice similar to this, where the urethra could not be found, and subsequently showed itself.

On the next day, February 13th, during my visit, the child passed water from the vaginal orifice. The operation was performed by Dr. Porter in the afternoon, the details of which were kindly given by him, and will appear later on. Three large dejections of meconium immediately followed, and three more during the next twelve hours. All food was retained after the operation, and no farther difficulty presented itself. The bowel was dilated occasionally, and for this purpose the ordinary glove-stretcher proved to be a most useful instrument.

Taking into consideration the development of the rectum in the foetus, it seemed to me more proper to term this variety imperforate rectum, rather than imperforate anus. This view is supported by Holmes² and others.

² Holmes's Surgery, pp. 810 and 815.

TABLE SHOWING THE FOOD.

Date.	Notes.	Teaspoonfuls.	
		Milk.	Water.
Feb. 12	Breast Milk and Goats tried. Will } retain no Food.	....	....
13	Operation.	....	....
14	Goats Milk given. All Food Retained.	$\frac{1}{2}$	2
15	Food given every one and one-half } hours. Few drops of Brandy } added.	$\frac{1}{2}$	2
16	....	$\frac{1}{2}$	2
17	Brandy Omitted. Food every two } hours.	2	4
18	All Food Retained.	2	4
19	....	2	4
20	....	2	4
21	....	3	5
22	Food given every two hours.	4	6
23	....	4	6
24	....	4	6
25	....	4	6
26	....	4	6
27	New Goats Milk given.	3	5
28	....	4	6
Mar. 1	....	3	5
2	....	3	5

TABLE SHOWING WEIGHT OF CHILD.

Notes.	Date.	Weight. lb. oz.	Notes.	Date.	Weight. lb. oz.
....	Feb. 11	4 7	....	26	5 4
....	12	....	....	27	5 5
Operation } Performed. }	13	....	Bowel Dilated.	28	5 6
Bowel Dilated.	14	4 2	....	Mar. 1	5 7
....	15	4 2	Bowel Dilated.	2	5 5
Bowel Dilated.	16	4 4	....	3	5 6
....	17	4 6	....	4	5 6
....	18	4 8	....	5	5 7
Bowel Dilated.	19	4 9	Bowel Dilated.	6	5 10
....	20	4 12	....	7	5 13
....	21	4 13	....	8	5 13
Bowel Dilated.	22	4 15	....	9	5 14
....	23	5	....	10	5 15
....	24	5 1	....	11	6 1
....	25	5 2	....	12	6 1
....					

“Cases of imperforate rectum may be divided into two classes, namely, those in which no anus exists, (imperforate anus, properly so-called), and those in which there is an anus leading into a cul-de-sac (imperforate rectum in the narrower sense of the term).

“The former class, (imperforate anus), may be again subdivided into (1) Membranous obstruction of the anus. (2) Complete or partial absence of the rectum. (3) Communication of the rectum with the vagina in the female. (4) Communications with the urinary tract in the male. (5) External communication, or fistula.

“The latter class (imperforate rectum) may be subdivided into (1) Membranous obstruction. (2) Deficiency of the upper portion of the rectum.

“We have now to consider the cases of imperforate rectum in the narrower sense of the term, that is, cases in which the external parts are normal, but the anus leads into a small cul-de-sac, the rectum being totally obstructed above.

“The obstruction of the rectum may be due to a simple membrane stretched across the tube of the intestine, which in other respects is natural; or the upper tube (the rectal cul-de-sac, as it is called), may lay by the side of the lower (the anal cul-de-sac), or behind it; or the rectum may be impervious for a greater or less distance, so that the colon may terminate by a dilated extremity above the pelvis. In rare cases the sigmoid flexure itself, and more or less of the rest of the large intestine, may be absent; but as such infants are usually not viable, the cases present little practical interest. Practically, cases of imperforate rectum may be divided, as above, into two classes, that is, (1) Where the upper cul-de-sac is accessible from the lower. (2) Where it is not.”

DISCUSSION.

DR. C. B. PORTER saw the infant first twenty-one hours after its birth; at that time no urine and no fæces had been passed. The most careful examination with small flexible bougies failed to find the meatus. The anal orifice was present, but on passing a large probe was found to terminate about one inch above the orifice in a cul-de-sac. The bearing-down efforts of the child were very feeble, and operative measures were advised to be postponed for twenty-four hours, in the hope that the rectal cul-de-sac would become more prominent, and the bearing-down efforts more vigorous. The wisdom of this course was fully demonstrated on the following day when a second examination was made. In the meantime the child had passed urine. Stretching the anal cul-de-sac and watching carefully it was seen that there was at varying intervals a rather uncertain bulging which seemed as though it might be the rectal cul-de-sac pressed down by the straining of the child.

Operation: A sharp-pointed, small, grooved needle was pushed from the apex of the anal cul-de-sac upwards as near as possible towards the centre of the prominence of the superior cul-de-sac. No fluid followed, but the point of the needle moved about as though in a cavity. A pair of sharp-pointed scissors was run along the groove of the needle and the blades opened, when alongside of them the meconium very thick and tarry followed. The child had three discharges within a short time, each stimulated by the introduction of the little finger. Dr. Porter saw the child twice after the operation, and each time dilated the passage by the introduction of the little finger; but there was no marked tendency to contraction. The vomiting which had persisted up to the time of the operation was completely relieved.

The points tending to the successful issue in this case, which was unfavorable from the fact that it was an eight months' child, were :

First: The delay for expulsive efforts to become more vigorous, to give an indication as to the location of the rectal pouch.

Second: The use of a small, sharp, grooved needle, instead of a trocar or knife, which would penetrate more easily a pouch which was not fully distended and not forced downwards by violent, expulsive efforts as is sometimes the case.

Third: The use of sharp-pointed scissors instead of the knife, as thereby not a drop of blood was lost and the size of the rent in the upper cul-de-sac was made to exactly correspond with the one in the lower, which could not have been as accurately affected by the knife.

There is always more or less danger of subsequent cicatricial contraction ; but the amount cannot be foretold, and in this case there has been so little that it is not probable that any trouble will result there from.

DR. STRONG asked if colotomy could not be performed as a temporary expedient to relieve the child, and whether later the blind intestinal end would not pouch down, so as to be reached *per anum*.

DR. PORTER replied, that inguinal colotomy might be performed for relief of the symptom of obstruction, but not with the hope that the rectal cul-de-sac would later become more prominent. But with an opening in the groin it might be possible to introduce a sound or some stiff instrument through the opening downwards into the rectal pouch and make it prominent in the region of the anal cul-de-sac, and thereby enable the surgeon to complete the artificial anus at that point and subsequently close the inguinal one.

DR. SINCLAIR inquired if imperforate rectum was found more frequently in girls than in boys.

DR. PORTER replied that he recalled at the moment only three cases in which he positively remembered the sex, and two of these were girls and one a boy. Dr. Porter subsequently contributed the following addition to his remarks on this subject :

In the catalogue of the Warren Museum the late Prof. J. B. S. Jackson makes this statement as the result of his examination and observation of post-mortem specimens of imperforate rectum and anus.

"In cases of imperforate anus, an opening into the 'bladder' or 'urethra' is occasionally reported; but so far as I have seen an opening into the membranous portion of the urethra is always found in an ordinary case of imperforate anus in the male subject. In extraordinary cases or where there is great malformation of the internal organs the opening may be into the fundus of the bladder, or there may be a great deficiency of the large intestine, and no opening at all. The opening is usually small but easily demonstrated, if the rectum is inflated under water."

"When the anus is imperforate in the female, the rectum opens into the vagina; and this opening seems to correspond to that in the male subject, the membranous portion of the urethra being the genital portion of the urinary canal."

In an analysis, by Mr. Curling, of one hundred cases of "Congenital Imperfections of the Rectum," with reference to an operation,² he gives twenty-six in which the intestine opened into the urethra or neck of the bladder, and he remarks that there "were very probably more; as the opening is sometimes so minute as to prevent the free escape of meconium during life."

In an analysis of 104 cases of "Imperforate Anus

² Med. Chir. Trans., Vol. xliii, p. 276.

and Rectum," by Dr. George H. Gay,³ he states that there was an operation in 77 cases: cures 25; deaths 52.

DR. GREEN had seen two cases of imperforate rectum in his Dispensary Obstetric Clinic. One case was in a boy, and there was a fistulous connection with either the bladder or the urethra. Dr. Beach operated on this case at the Massachusetts General Hospital and established an opening *per anum*; but the child died in thirty-six hours. The second case was in a girl, and was successfully operated on by Dr. Gay at the City Hospital: the infant passed feces easily for several days, and undoubtedly would have lived, with proper care; but it was neglected by the family and pined away.

Apart, however, from the presence and successful treatment of imperforate rectum, Dr. Hayward's case was one of great interest; not only as a triumph for antiseptic obstetrics, with speedy, non-febrile recovery after version and manual removal of an adherent placenta, but also on account of the successful care of a premature child.

The great desideratum in the care of the premature infant is the maintenance of bodily heat. This may often be accomplished by hot-water bottles and heaters; but the most effective apparatus is the hot-water cradle, or the *conveuse* of Tarnier. When these cannot be obtained, a very good substitute can be improvised by the use of two tin pans or foot-tubs of such relative size that one can be placed in the other and surrounded by hot water, as described by Worcester in his *Manual on "Monthly Nursing,"* page 212.

DR. W. L. RICHARDSON said the case seemed one of exceptional interest. The fact that the temperature during the convalescence never exceeded 99° bore testimony to the efficient manner in which the antiseptic

³ Boston Med. and Surg. Jour., Vol. lvii, p. 397.

tic method of treating such cases had been carried out. He agreed with Dr. Reynolds that the great majority of cases of so-called adherent placenta were not cases in which there was any morbid attachment of the placenta to the uterine wall. Cases in which such attachment exists are rare, in comparison with the number of cases reported; but they do occur, and oftentimes are extremely difficult to manage. In cases where a patient has had, during her pregnancy, a threatening miscarriage with hæmorrhage, it is very common to find the placenta morbidly adherent over the area, where, evidently, the previous placental separation had taken place. The partial separation, with its accompanying hæmorrhage, seems to set up an inflammatory action sufficient to cause an adhesion. The necessity of keeping a premature child sufficiently warm is also well illustrated in the result of this case. The popular saying, that seven months' children live, while eight months' die, is, unfortunately, entitled to some weight, if we only look at statistics. The reason, however, is to be found in the neglect to properly keep up the animal heat, the loss of which is badly borne by premature children. A seven months' child is, of itself, a curiosity, and is most carefully watched, while an eight months' child so nearly resembles one at full term, that, after the first few days, the novelty is over, and the child is very apt to die from a neglect to keep it sufficiently warm.

An eight months' child requires just as much care for four weeks, as a seven months' child does for eight. The neglect of such precaution is apt to allow of a loss of animal heat, and a convulsion not infrequently closes the scene. Since the introduction of so-called "incubators" at the Boston Lying-in Hospital, the mortality among the premature babies has very decidedly improved. The result of the operation by Dr. Porter was most successful. At the Lying-in Hospi-

tal, there have been five cases of imperforate rectum in about 3,500 births. Four of the children were males, and one was female. One of the cases was still-born, and was the result of a pregnancy complicated with hydramnios. Three of the babies were operated upon by surgeons. Two of these lived twenty-four hours, and one for three days after the operation. In one case the malformation was not operated upon, the child dying on the third day. In the three cases which were operated upon, the babies all presented symptoms of intestinal obstruction, such as vomiting, colicky pains, and evident distress, with abdominal bearing-down efforts. These symptoms were at once relieved by the operation. The case which died without any operation showed no symptoms of any intestinal obstruction.

DR. SINCLAIR had seen several cases in which, on attempting to empty the uterus *post partum* on account of hæmorrhage, the placenta was found adherent and sometimes had to be removed piecemeal. In Sir James Simpson's Edinburgh collection is a fine specimen of adherent placenta, presented to the museum by the patient's husband, as a warning against the practice of pulling on the cord by midwives. Calcareous placenta are not necessarily adherent; but the children in such cases often die in utero on account of impaired nutrition.

DR. BLAKE said it was not uncommon to find degenerative changes and calcareous deposits in the placenta, with adhesions in some cases. In one case the connection was very intimate, of a fibroid or cord-like nature.

